Marjorie S. Greenberg
Acting Executive Secretary
National Center for Health Statistics
6525 Belcrest Road, Room 1100
Hyattsville, Maryland 20782

Dear Marjorie:

NCPDP appreciates the opportunity to respond to the questions presented by the National Committee on Vital and Health Statistics, the federal advisory committee to the Department of Health and Human Services on health data, privacy and health information policy.

As you recall, Bill Braithwaite stated that NCPDP does not need to have a speaker during the "code set" panel during the April 15-16, 1997 session. His reasoning was that the pharmaceutical industry does not have any controversies with respect to code sets.

If the National Committee on Vital and Health Statistics members have any questions regarding our responses, please feel free to contact me at (602)957-9105, ext. 110.

Sincerely,

Daniel J. Staniec, R.Ph., MBA
Executive Vice President of External Affairs

NCPDP Standardization Co-Chairs
Deborah L. Stroup- NCPDP Chair
Phillip Scott- NCPDP Chair Elect
Lee Ann Stember- NCPDP President

Question 1- What medical/clinical codes and classifications do you use in administrative transactions now? What do you perceive as the main strengths and weaknesses of current methods for coding and classification of encounter and/or enrollment data?

NCPDP uses the NDC (National Drug Code) number to identify drug products and medical supply items for the purpose of transmission and reimbursement of claims. The numbers are 11 (eleven) digits in length and they are all numeric. The format is as follows:

The first five digits represent the labeler identifier assigned by the Federal Food and Drug Administration (FDA). The next four digits represent the product (drug and strength). The last two digits represent the package size. The NDC is often represented on product labels in a ten digit format instead of the standard eleven. In this case, a non-significant zero must be added to the number to produce the standard eleven digit format for billing purposes. The following are the only possible formats for NDC's:

- 4-4-2 (NDC) a zero placed in position one
- 5-3-2 (NDC) a zero placed in position six
- 5-4-1 (NDC) a zero placed in position ten

NDC's are required for all prescription drugs and are optional for over the counter drugs and devices. All of the standard drug databases use these numbers for the purpose of positive product identification. They have been in use since the mid 1960's and has proven to be a valuable tool for the transmission of drug product information.

The main strengths of the NDC number are as follows:

- universally used throughout the industry (only one standard for this purpose)
- ease of implementation
- ease of accessibility

There are no weaknesses with respect to the NDC number.

NCPDP also supports an Alternate Product Type/ID. The Universal Product Code (UPC) are used for drugs that do not require a prescription (over the counter). The UPC format is as follows:

The first five digits represent the labeler code (assigned by the Universal Code Council). The next five digits represent the product. The following are possible formats for UPC codes:

- 5-5 (UPC:5-03-2) a zero placed in the position six
- 5-5 (UPC:5-4-01) a zero placed in position ten
- 5-5 (UPC:5-4-10) a zero placed in position eleven

Another code set used by the pharmaceutical industry is the number assigned to supplies and devices. This number is called the Health Related Item (HRI). The HRI number format is as follows: 4-4-2 (HRI:04-4-2) a zero placed in position one. UPCs and HRIs satisfy the needs of the pharmaceutical industry.

Professional Pharmacy Services Codes (PPS) were actually created by NCPDP. The purpose of these codes is to create an electronic documentation and billing infrastructure to support efficient compensation mechanisms for the delivery of professional services by pharmacists to their patients who are enrolled in third-party pharmacy service benefit plans.

The core of the PPS module consists of three fields:

- Reason for Service (Conflict)
- Professional Service (Intervention)
- Result of Service (Outcome)

The service field codes can be transmitted to either describe a problem or request the pharmacy to review a possible conflict identified by the payer. The professional service field was created to describe the professional service the pharmacist performed in responding to the problem identified or service requested. The result of service code was created to accommodate the description of how the problem was resolved.

The main strengths of the PPS codes are as follows:

- ease of implementation
- ease of accessibility
- only one standard in pharmacy for this purpose

There are no perceived weaknesses with respect to the PPS codes.

Another code set created by NCPDP and are used in the pharmaceutical industry affects the actual payment of claims. These codes are called Dispense as Written (DAW) codes. The following is a list of the DAW code definitions:

0 = No product selection indicated

1 = Substitution not allowed by provider

2 = Substitution allowed- patient requested product dispensed

3 = Substitution allowed- pharmacist selected product dispensed

4 = Substitution allowed- generic drug not in stock

5 = Substitution allowed- brand drug dispensed as generic

6 = Override

7 = Substitution not allowed- brand drug mandated by law

8 = Substitution allowed- generic drug not available in marketplace

9 = Other

The pharmaceutical industry also uses the ICD-9 codes. There is a field in the NCPDP Telecommunication standard that accommodates the ICD-9 codes.

Question 2- What medical/clinical codes and classifications do you recommend as initial standards for administrative transactions, given the time frames in the HIPAA? What specific suggestions would you like to see implemented regarding coding and classification?

NCPDP recommends that the NDC, UPC, HRI, ICD-9, and the NCPDP PPS and DAW codes be adopted by the Secretary. It is important that the entire pharmaceutical industry is notified with respect to the Secretary's decision(s).

Question 3- Prior to the passage of HIPAA, the National Center for Health Statistics initiated development of a clinical modification of ICD-10 (ICD-10-CM), and the Health Care Financing Administration undertook development of a new procedure coding system for inpatient procedures (called ICD-10-PCS), with a plan to implement them simultaneously in the year 2000. On the pre-HIPAA schedule, they will be released to the field for evaluation and testing by 1998. If some version of ICD is to be used for administrative transactions, do you think it should by ICD-9-CM or ICD-10-CM and ICD-10-PCS, assuming that field evaluations are generally positive?

The NCPDP Telecommunication Standard has an optional claim information section that has a diagnosis code field (Field 424-DO). Currently, the code used is the ICD-9 code. In a future version, (Version X.Y), a qualifier field will be added to accommodate either the ICD-9 or ICD-10 codes.

Question 4- Recognizing that the goal of P.L. 104-191 is administrative simplification, how, from your perspective, would you deal with the current coding environment to improve simplification, reduce administrative burden, but also obtain medically meaningful information?

NCPDP applauds the efforts undertaken by the NCVHS to receive feedback from all industry perspectives to make informed decisions about code sets. If code sets can be transmitted in an electronic environment versus a paper environment, administrative costs will be reduced dramatically. Once the Secretary adopts the standard code sets, there must be a massive educational effort to all industry perspectives, i.e., payers, providers, etc. to help during the implementation and transition phases of these recommended code sets.

Question 5- How should the ongoing maintenance of medical/clinical code sets and the responsibility, intellectual input and funding for maintenance be addressed for the classifications systems included in the standards? What are the arguments for having these systems in the public domain versus the private sector, with or without copyright?

Code sets must be maintained and updated on a periodic basis to provide quality information. Our recommendation is to allow the private industry who already maintains code sets to maintain them in the future. This organizational

framework is already in place for this to occur, such as software, staff, and so forth. The industry knows who maintains these codes sets now, and where to place an order for the codes sets.

However, if the ICD-10-CM and ICD-10-PCS are approved and are made available from HCFA to the private industry, we would support such a decision. This is very similar to the HCFA NPI and PAYER ID projects, which NCPDP also supports.

Question 6- What would be the resource implications of changing from the coding and classification systems that you currently are using in administrative transactions to other systems? How do you weigh the costs and benefits of making such changes?

Since there are no alternative standards to the NDC number and the NCPDP PPS codes, this is a moot issue. However, if only ICD-10 code sets are chosen, system changes would have to be made to the legacy systems (payers/processors) as well as to the software vendors systems.

The ICD-10 codes will have an increased length from ICD-9 codes. NCPDP is preparing to create a qualifier field in the NCPDP Telecommunication Standard to accommodate the ICD-10 type codes to avoid additional costs.

Question 7- A Coding and Classification Implementation Team has been established within the Department of Health and Human Services to address the requirements of P.L. 104-191. Does your organization have any concerns about the process being undertaken by the Department to carry out the requirements of the law in regard to coding and classification issues? If so, what are those concerns and what suggestions do you have for improvements?

NCPDP is pleased with the process being undertaken by the Department to carry out the law in regards to coding and classification issues. In addition, NCPDP appreciates your openness and desire for meaningful private sector input.